**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

FREDERICK MERIAN, MD
3100 TIMMONS LANE #250
HOUSTON, TX 77027

**Respondent Name**

WESLACO ISD

**Carrier's Austin Representative Box**

Box Number 29

**MFDR Tracking Number**

M4-11-3208-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "CARRIER REFUSES TO PAY THE FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

**Amount in Dispute:** $265.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Please see the attached DWC-32 where the Carrier clearly requested the Designated Dr address the impairment rating only. Please see the attached Texas Department of Insurance appointment letter (EES-14) dated 3/11/11 which indicates the purpose of the exam is to determine the Impairment Rating only. Please see the attached DWC-69 report from Designated Dr.Frederick Merian where he addressed both Maximum Medical Improvement and Impairment Rating. We feel that our payment is accurate in accordance with what was to be addressed and nothing more."

**Response Submitted by:** Tristar Risk Management, P.O. Box 60072, Corpus Christi, TX 78466

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 25, 2011 | 99456-W5-WP | $265.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated May 04, 2011
   - 2H – The service has been rendered in a rural area which meets the definition of a Health Professional Shortage Area (HPSA).

   Explanation of benefits dated May 11, 2011
   - T193 – No additional reimbursement allowed after review of appeal/reconsideration.
   - TW1 – Fee Schedule.

**Issues**

1. What Designated Doctor (DD) services did the Division order?
2. Is the requestor entitled to reimbursement for disputed services under 28 Texas Administrative Code §134.204?

**Findings**

1. The Division order on the EES-14 form was to address Impairment Rating (IR) only. The requestor (DD) has billed $650.00 for one body area/unit of CPT code 99456-W5-WP. Documentation supports an impairment rating via range of motion for the shoulders (upper extremity) payable at $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). The narrative documentation states, "It was previously determined that the examinee reached Maximum Medical Improvement on 02/25/2011; therefore, it was not requested that I assign a date of Maximum Medical Improvement." Therefore, there is no reimbursement for a MMI determination that did not occur nor was requested and the only reimbursement would be the MAR for this IR which is $300.00.
2. The respondent has paid an amount of $385.00 for the assignment of an IR. Therefore, the requestor is not entitled to any additional reimbursement.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | February 02, 2012<br>Date |
|---|---|---|

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.